VETERAN'S ADMINISTRATION DUBIOUS CONTRACTING PRACTICES: SAVANNAH

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

MARCH 6, 2012

Serial No. 112–47

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

73–292 WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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VETERAN'S ADMINISTRATION DUBIOUS CONTRACTING PRACTICES: SAVANNAH

TUESDAY, MARCH 6, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Committee met, pursuant to notice, at 12:03 p.m., in Room 334, Cannon House Office Building, Hon. Bill Johnson, [Chairman of the Subcommittee] presiding.

Present: Representatives Johnson, Donnelly, McNerney, and Barrow.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Mr. JOHNSON. Good morning. This hearing will come to order. I want to welcome everyone to today's hearing on the VA'S Dubious Contracting Practices: Savannah.

As this Subcommittee made clear to the VA in its invitation to this hearing, we are examining the proposed clinic in Savannah as a case study for the rest of the country. We have evidence of similar dubious practices taking place at other locations, and our intent is to have the VA fix the problems and conduct necessary oversight at all of its construction sites.

The problematic practices referred to in today's hearing title have to do with the VA exceeding the size and scope of requested authorizations, conducting haphazard due diligence, and not being forthcoming about its actions to Congress.

In fact, this Subcommittee contacted the VA last year with several specific concerns about this site in Savannah with the hopes of helping the VA conduct better business. The response was disheartening. Despite the specific concerns cited, the VA dismissed the Subcommittee's efforts to reach out and work together, instead giving a cursory response.

When the VA selects a site, such as Savannah, and requests a specific authorization from this Committee, it is reasonable to expect that the VA intends to move forward toward those goals. As is the case with Savannah and many other sites around the country, the VA's actions have not matched its words.

In its fiscal year 2013 budget request, the VA claims to use, and I quote, the best infrastructure planning practices from both the private and public sectors to integrate all capital investment planning, end of quote.

It is my hope today, that today's discussions elaborate on those best practices the VA says it uses, as well as best practices that it declines to use.

The VA's fiscal year 2009 budget request includes an authorization request of over $3 million for expansion of its Savannah CBOC, with an annual rent of over a million dollars. The fiscal year 2013 budget includes the same authorization amount and the same net usable square feet for what the VA refers to as a "satellite outpatient clinic." On the surface, things appear to be the same.

However, in 2009, the VA issued a request for a proposal for nine to twelve acres in Savannah that could accommodate constructing an outpatient clinic. The difference between what the VA had proposed to Congress less than a year earlier and what it was moving forward with in the community was significant.

Among the alternatives submitted in its fiscal year 2009 budget submission to Congress, the VA stated that constructing an outpatient clinic and I quote, burdens VA with additional owned infrastructure.

Conversely, a November 2010 letter from Glenn Haggstrom, the VA's Executive Director for Acquisition, Logistics, and Construction, can't say enough good things about the VA building new construction.

Notwithstanding the lack of communication with Congress, the VA also stumbled through its acquisition process, using an incomplete and careless appraisal process that according to many involved in commercial real estate lacks common sense. To veterans, taxpayers, and Congress, the resulting concern is that the VA is failing to get the best value.

Based off the original fiscal year '09 budget request, the expanded Savannah clinic would be occupied in June of 2011. In the most recent budget request submitted just a few weeks ago, the status is listed as "acquisition process initiated."

As I mentioned earlier, this is not an isolated incident, and the veterans in need of services are the ones being harmed by delays, cost overruns, and failure to thoroughly analyze costs and the benefits associated with every alternative.

I look forward to an honest discussion today on the VA's methodology, including mistakes and missteps. I further hope to hear solutions that can bring veterans in Savannah and throughout the country a timely delivery of health care services at the best value.

I now recognize the Ranking Member for his opening statement.

[The prepared statement of Bill Johnson appears on p. 19.]

OPENING STATEMENT OF HON. JOE DONNELLY, RANKING DEMOCRATIC MEMBER

Mr. DONNELLY. Thank you, Chairman Johnson for holding this hearing.

Today's hearing will explore, in detail, issues surrounding the major medical facility lease for expanding the community-based outpatient clinic in Savannah, Georgia. By closely looking at one such facility, it will help us get a clear picture of how this vital program is currently operating.

Beginning with last year's budget submission, the VA's construction and leasing decisions are made under the VA's Strategic Capital Investment Planning process. Lease projects are an important component of the VA's effort to modernize its health care delivery system and provide greater access for our veterans.

Because of its importance for the provision of quality health care, it is essential that the lease process be as quick, fair, and transparent as possible. This includes keeping Congress informed of important decisions and making sure that taxpayer dollars are spent as wisely as possible.

The VA sought congressional authorization for the Savannah, Georgia clinic in its FY 2009 budget submission. This authority, for a clinic with 38,900 net usable square feet at a cost of $3.2 million, was provided in October 2008.

Some time after this authorization, the VA expanded the project and is now seeking to lease a clinic with a maximum net usable square footage of 55,193. The VA has not notified Congress or sought additional authorization. And in addition, construction is now going forward at this time, although it was authorized in 2008.

The clinic in Savannah is a project that we continue to work on, and in addition to exploring how and why VA feels it has the authority to move forward on projects with a larger scope than authorized, I am hopeful we will get a better idea as to the time frame, not only—for all of these projects.

I look forward to hearing from our witnesses and getting a better understanding how the lease program operates, as well as exploring possible changes to the program that may be necessary to ensure that VA and Congress are working together, and that the process from identifying leasing opportunities up to the ribbon-cutting ceremonies is fair, fast, economical, transparent and efficient. Thank you and I yield back.

[The prepared statement of Joe Donnelly appears on p. 20.]

Mr. JOHNSON. I thank the gentleman for yielding back. I would now like to welcome the panel to the witness table, and I see they're already assembled. On this panel, we will hear from Robert Neary, Acting Executive Director of the Office of Construction and Facilities Management at the Department of Veterans Affairs. He is accompanied by George Szwarcman, Director of Real Property Services at the Department of Veterans Affairs, and Brandi Fate, Director of Capital Asset Management and Support in the Veterans Health Administration.

Mr. Neary, you're now recognized for your testimony.

STATEMENT OF ROBERT L. NEARY, ACTING EXECUTIVE DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, ACCOMPANIED BY GEORGE SZWARCMAN, DIRECTOR, REAL PROPERTY SERVICES; BRANDI FATE, DIRECTOR, CAPITAL ASSET MANAGEMENT AND SUPPORT

STATEMENT OF ROBERT L. NEARY

Mr. NEARY. Thank you, Chairman Johnson and Ranking Member Donnelly, and Members of the Subcommittee.

I appreciate the opportunity to testify on the Department of Veterans Affairs' contracting practices for our leasing and specifically the Savannah, Georgia clinic.

You've introduced my colleagues, I would ask that my complete written statement be included in the hearing record.

First, I would like to thank the Members of the Committee for bringing a discrepancy within VA's 2010 appraisal of the site selected in Savannah to VA's attention, and allowing me to testify on the subject. I will begin by providing this committee the most current information on VA's actions concerning this matter.

In response to a series of questions from the Subcommittee in December of 2011, VA provided incorrect data regarding the size of a comparable property that was used within the appraisal for the selected site of the relocated clinic. Instead of correctly referencing a comparable property of 46.85 acres, VA's certified appraiser believed this comparable sale referenced a 16.85 acre location. VA provided this data based on confirmation in December 2011 from the appraiser, that he had performed appropriate due diligence regarding comparable properties for VA's appraisal of the selected site.

VA has since conducted further research, that reveals the source of the inaccurate information, which was based on a discrepancy between the records of Chatham County, Georgia and the recorded deed for the comparable property.

Since learning of the discrepancy, VA immediately requested that its appraiser revise his appraisal and provided an update to the Subcommittee on March 2nd, acknowledging the error.

VA is also contracting for—with another certified appraiser to review the initial appraisal, and provide a determination regarding the fair market value of VA's selected site as of the spring of 2010, as well as providing a new appraisal that reflects the current land value of the site.

We will review all the appraisal reports concerning the selected site in Savannah in order to determine what appropriate corrective measures should be taken.

I would like to assure the Subcommittee that VA only uses appraisers who maintain appropriate licensure and accreditation, and are experienced with the requirements of the Uniform Appraisal Standards for Federal Land Acquisition.

I would again like to thank the Subcommittee for drawing VA's attention to the discrepancy and apologize for VA's delay in uncovering the facts. And additionally, provide assurance that responses to future inquiries will be more thoroughly investigated.

I'd also like to take this opportunity to provide an update on the delivery of the Savannah clinic, and provide information on VA's leasing program in general.

Leasing is an essential tool utilized by VA to provide high quality facilities to serve our Nation's veterans. VA currently leases approximately 13.4 million square feet of medical space in support of the health care system that serves veterans.

The lease for the first Savannah clinic was entered into in 1991 and was set to expire in 2011. Due to the expiration of the 20-year existing lease, which is VA's maximum authority, and due to the

growing demand for health care services, VA determined that a new lease for Savannah was required.

It is important to note VA continues operations at the current facility through a succeeding lease, to maintain continuity and veteran care until a new space is procured and activated.

In fiscal year, Congress authorized $3,168,000 for a new 38,900 square feet clinic. However, in 2009, the Charleston VA Medical Center, Savannah's parent facility, raised its request to over 55,000 square feet, based on an increased projection in veteran patient workload, the need for enhanced mental health, optometry, and radiology services, and the addition of audiology services, to provide additional health care resources for Savannah veterans.

For large leases such as this, VA typically uses a two-step process for obtaining built-to-suit lease based medical facility. Step one is advertising and selecting a site, and obtaining an assignable option to purchase. Step two is conducting a best value procurement for a developer to design and build the facility.

VA is currently near the end of the two step process and evaluating final proposals from developers occurred in December. Based on updated space requirements, the current market base pricing for the 55,000 net usable square foot facility, indicates a cost that exceeds by more than 10 percent the amount authorized by Congress in 2009.

Once we have resolved the issue with the appraisal, and in accordance with 38 U.S.C. 8104(c), VA will submit a notice to the Committees of VA's intent to proceed with the lease.

We look forward to completion of the facility and to providing enhanced care to veterans in Savannah, and I look forward to answering any questions the Subcommittee has regarding the Savannah lease procurement or other aspects of VA's leasing programs. Thank you, Mr. Chairman.

[The prepared statement of Robert Neary appears on p. 21.]

Mr. JOHNSON. Thank you, Mr. Neary, for your testimony. We'll now begin with the questioning and I'll begin.

The VA clearly indicates in a letter from Secretary Gould on the 24th of November 2010, that they automatically go to the two-step acquisition process, which by definition, precludes evaluation of existing lease space as an option, for all leases greater than 20,000 square feet.

Does VA presume that this authorizes them to bypass the requirements of Federal Acquisition Regulations in 38 U.S.C. Section 8104(b)?

Mr. NEARY. No, sir, we do not presume that we've got authority to violate either Title 38 or the Federal Acquisition Regulations.

Mr. JOHNSON. Why did the three annual lease status report submitted to Congress since 2009 continue to repeat the original authorization amounts, when the VA clearly knew their efforts were not consistent with the Congressional limits?

Mr. NEARY. Sir, I think our current process for the past several years has been to notify the Congress, or to notify the Committees on Veterans Affairs when we are planning to enter into a lease that exceeds what was authorized by greater than 10 percent. And our practice has been to do that after we have received market based pricing based on our procurement.

Now, in this case, significant time has passed since the original authorization. But that's the reason that we have not notified the Committee. We're waiting for price proposals to be received through competition.

Mr. JOHNSON. Okay. I'd like to point out that the Green Bay Clinic is a similar scenario. The FY'09 budget authority request was for 70,600 square feet, $2,008,000 annual rent and $3,883,000 initial payment. Total budget authorized over 20 years was 44,000—I'm sorry, 44,043,000.

As recently as to the 2012 submission to Congress, the VA has indicated in the lease status report that Green Bay lease was not changed from FY'09 authorization request; however, SFO VA–101–09–RP–0200 issued 6/24/09 was for 161,525 square feet, 228 percent higher than authorized. And news reports indicate that the Green Bay lease has now been awarded.

Let me ask you another question, has the VA already paid approximately 100,000 or so for a purchase option on the land in Savannah?

Mr. NEARY. That's correct, Mr. Chairman.

Mr. JOHNSON. Under what authority does VA purchase an option to buy real property?

Mr. NEARY. I'd like to ask Mr. Szwarcman to answer that.

Mr. SZWARCMAN. Thank you, Mr. Neary, thank you, Mr. Chairman.

VA, according to a decision or an opinion by the Office of General Counsel, VA does have authority to purchase options, to purchase real property. The only distinction I would make in this case is that VA is purchasing an option for an assignable option, or I should say, yeah, purchases an option to buy that property which will be assigned to the eventual developer. So it is never really the intent of VA to acquire a piece of property such as in Savannah for VA to own.

Mr. JOHNSON. You know, the—I think the operative word here is to purchase an option. The red book makes it clear that agencies need a specific statutory authority to purchase an option. This is a separate authority than the authority to buy real property out right.

I can refer you to that, to the red book. A quick search of VA's authorities do not provide an authority for their action. So I'm a little bit lost with that.

There's a difference between purchasing an option and purchasing property out right. Has the VA obligated itself to purchase the land?

Mr. NEARY. No, sir, we've not. We——

Mr. JOHNSON. And if the land is not purchased, will VA get any of that money back?

Mr. NEARY. No, sir.

Mr. JOHNSON. So that's taxpayer dollars down the drain?

Mr. NEARY. If a decision were made not to acquire that site, then money would be lost, yes.

Mr. JOHNSON. Okay. Why did VA ask for money to expand while simultaneously planning to build a new facility well over the authorized project limit?

Mr. NEARY. Sir, I'm not sure I understand the question.

Mr. JOHNSON. It's a simple question. Why?

Mr. NEARY. We asked for authority to enter into a new lease, which would be an expanded lease, correct.

Mr. JOHNSON. An expansion of the current facility?

Mr. NEARY. Not the expansion of the current facility, an expansion of space within Savannah. It was our conclusion as the planning process proceeded, that the existing facility could not be effectively expanded to meet VA's requirement, while VA continued to operate a clinic there.

Mr. JOHNSON. But all the while, planning instead to build a new facility well over the authorized limit that was in the expansion, correct?

Mr. NEARY. We have planned to provide space in excess of the authorized limit, and in accordance with the provision in Title 38 and long standing practice, we communicate that via notification letter to the Committee.

Mr. JOHNSON. I'll have another round of questions, but I'll yield now to the Ranking Member for his questions.

Mr. DONNELLY. Thank you, Mr. Chairman.

In regards to the Savannah project, there was a 3 year delay, what would you attribute that to primarily? And do these delays almost automatically come about because of the way the process is designed at this time?

Mr. NEARY. No, sir, I don't believe that this is a common practice. In Savannah, we encountered three hurdles that contributed to the delay.

The first, once the project was authorized in 2008, it became evident locally and to the Veteran's Health Administration, that the number of veterans who would be using the facility was growing, and that additional services will be needed. And there was a period of time spent in validating the space requirement, determining what would be the appropriate space requirement. So that was number one.

Number two, we initially selected a site and the land owner of that site, after extensive negotiations, concluded that they were not willing to sell the site to the government.

And number three, we had an architectural and engineering firm under contract to support us in the development of the early design. Unfortunately, that firm was not performing up to what we considered acceptable standards, and it was necessary to bring in a second firm to prepare the design.

So those three items, validating the requirement, of moving to site number—choice number two, and negotiating the agreement, and retaining a second AE were major contributing factors to delay.

Mr. DONNELLY. When and do you plan to seek additional authorization for the Savannah facility and the other facilities where the size, the scope, et cetera, is significantly increased?

Mr. NEARY. Sir, by agreement with the Committees over time, a notification letter as opposed to a new authorization by law is the process to have that communication and advise the Committees of our intentions.

And once we have resolved the issue that's arisen because of the erroneous appraisal, the Department would expect to submit such notification to the Committees, advising of what our intentions are.

Mr. DONNELLY. Okay. And this facility is becoming significantly larger in size. How do you plan to fund the increase in costs on this?

Mr. NEARY. I'll ask Ms. Fate to answer that question.

Ms. FATE. Thank you, sir. The—with the existing clinic, the funding for the existing lease is within our current base of the funding that we have in our medical facilities. And the increase is planned to be absorbed in our request for an increase in 2014 appropriation.

Mr. DONNELLY. And then we would also like to get a copy of the General Counsel's opinion as well.

Mr. NEARY. Yes, sir.

Mr. DONNELLY. Thank you very much. Thank you, Mr. Chairman.

Mr. JOHNSON. I thank the gentleman for yielding. We'll now go to Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. Neary, a recent Inspector General audit of the VA's enhanced use lease authority stated that the program needs improvements. One of the items mentioned is that there were often delays in executing lease programs. Can you provide an example or two of the delays why they have occurred, and how the VA is working to prevent that from happening in the future?

Mr. NEARY. Certainly, sir. With respect to the enhanced use leasing program, I'm not intimately involved in that program and would be unable to comment on that. But in terms of the more traditional leases that my office is responsible for, as I mentioned the—in the case of Savannah, the need to revalidate and consider increasing the space contributed to the delay, one of the things that the Department has seen, as you well know in recent years, is many more veterans coming to the VA, and also a decision by the health care system to provide more sophisticated medical services in some of these clinics, in some of these larger clinics.

And so I think that as an example of delay, the need to validate and make sure we're getting it right in terms of the space that we would provide is one of the things that contributed to this delay and has contributed to some others.

Mr. MCNERNEY. Do you have another example in mind?

Mr. NEARY. We, on occasion, get into more protracted negotiations with land owners. Sometimes we have a difficulty finding an adequate site in some areas, particularly in urban areas where we would want to have a clinic located near the population centers for easier access by veterans. And often times, it's difficult to identify property and reach a satisfactory negotiation with land owners.

So identifying and an agreement on the site could contribute to delay as well.

Mr. MCNERNEY. I've been a little frustrated with a project in my district at the French Camp facility and the delay that it's taken so long to get that identified, and now get started. Can you give me some concrete hope on when we might move forward on that facility?

Mr. NEARY. Certainly, sir. That facility and the second clinic is an important priority for the VA. If I could just take a second and look something up here.

We have retained an architectural firm to begin the design. I think as you know, we've been funded $55.4 million in the budget for this fiscal year, fiscal year 2012, awarded a design contract, and we are moving forward to begin the design. We have completed the acquisition of both the French Camp and the second site that's associated with that initiative.

Mr. MCNERNEY. So we'll break ground within a year?

Mr. NEARY. Sir, the breaking of ground will be dependent upon when we receive construction funding. The funding is not in the 2013 budget. It, along with other initiatives, will be a consideration as we build the 2014 budget, and we'll be positioned to break ground as soon as we have construction funding available.

Mr. MCNERNEY. Well, would you agree that the IG report that I referred to earlier highlights serious flaws within the VA's goal to end veteran homelessness?

Mr. NEARY. Sir, I'm not able to comment on the VA's homeless program and the enhanced use. Ms. Fate, would you have—or provide for the record.

Ms. FATE. Thank you, sir. We'd like to provide for the record the questions that you have for the homeless.

Mr. MCNERNEY. Okay. Thank you, I'll yield.

Mr. JOHNSON. I thank the gentleman for yielding back. I will now go to my colleague, Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chairman.

Mr. Neary, thank you for being here today. Just a couple of matters, and then I want to yield the balance of my time to the chairman in the interest of continuity and the questions he was following up on.

First at the outset, there's standard language in the appropriations bills that we pass, to the effect that, and I want to quote the most recent one, "The scope of work for a project included in 'construction major projects' may not be increased above the scope specified for that project and the original justification date provided to the Congress as part of this request for appropriations."

Meaning anything like that, that applies specifically to the facility leasing program, the major facility leasing program, in your opinion, would it be a useful thing for us to do to include in appropriations language a similar limitation on projects that are included in the major leasing—major facility leasing program, either in the Appropriations Act that we enact from year-to-year, or in general legislation in Title 38? Would that be a good idea?

Mr. NEARY. Sir, in my opinion, it is my opinion not as a Department, but I think we and the Committee need to work together to ensure that when an appropriate change is necessary it can be implemented effectively and efficiently.

One of my concerns about requiring an entire new authorization is that it could—that act could result in a potentially 1 year delay in that initiative. But I certainly agree that we need to have effective communications with the Committee, and if the Congress were to choose to implement that, we'd obviously follow that guidance.

Mr. BARROW. Thank you. As somebody who represents both the City of Savannah and Augusta, I can tell you that the folks right up the road in Statesboro, Georgia regard Augusta as their parent facility. It's right down the road. Savannah looks to Charleston as its parent facility.

I gather that by, you know, 15 minutes or so, a difference in drive, but I can tell you as someone who's driven both directions, it's a much easier drive up to Augusta than it is over to Charleston. And folks feel a stronger pull in the direction of the river to a principal city in their own state, than they do a principal city elsewhere.

What all is involved in transferring a CBOC like the one in Savannah from its nearest parent facility like in Charleston to a more effective parent facility right up the road in their own state? What all is involved in something like that?

Mr. NEARY. Ms. Fate, would you answer that?

Ms. FATE. Thank you for the question. It's a—the demographics of where the boundaries are for all the parent facilities across the country are based on where veterans live. And it's a very sophisticated complex mapping of where each parent facility is mapping to their—every CBOC that they have that they support.

We can get you the specifics of why Charleston supports Savannah, as opposed to Augusta supporting Savannah, and take that for the record——

Mr. BARROW. I only want the——

Ms. FATE [continuing]. To get you——

Mr. BARROW [continuing]. Parent facility that's most conducive to the needs of the veterans in the Savannah area, that's all. But I can tell you there's a lot more sense of pull in one direction than there is another, and a whole lot less difficulty in getting from one to the other from personal experience.

With that, Mr. Chairman, I want—in the interest of continuity, I want to yield the balance of my time to the Chairman, so he can follow up with the line of questions he was engaged in before. Thank you, Mr. Chairman.

Mr. JOHNSON. I thank my colleague for yielding.

Did—Mr. Neary, did the VA submit a report to Congress on their detailed plan to construct a new facility in Savannah and provide a cost benefit analysis of new versus expansion of the existing facility?

Mr. NEARY. A cost benefit analysis was conducted. I'm not sure if that was provided to the Congress or not. We could check on that.

Mr. JOHNSON. Was a detailed plan submitted?

Mr. NEARY. A prospectus was submitted at the time that would outline what the plan was, yes, sir.

Mr. JOHNSON. Okay. Under—and we acknowledged just a few minutes ago, you said the VA is not exempt from Title 38 U.S.C. Section 8104(b). Under that provision, the Secretary must submit to each committee on the same day, a prospectus of the proposed medical facility including a detailed cost-benefit analysis comparing total cost of new construction versus utilization of existed or expanded lease space.

Do you have a copy of your cost benefit analysis with you?

Mr. NEARY. No, sir, I do not.

Mr. JOHNSON. I do, Mr. Neary. That's it. One page. 8104(b) requires a detailed cost benefit analysis. Here is a cost benefit analysis of a similar size and cost project for the Martin Luther King Memorial Library. It's over a quarter of an inch thick with detail, the operative word is detailed, not an executive summary, but a detailed cost benefit analysis. So I would submit to you, that the VA did not submit a detailed cost benefit analysis as required by Section 8104(b).

Approximately how many real estate firms or brokers does the VA use to assist in its leasing and site acquisitions such as with Public Properties, LLC in Savannah?

Mr. NEARY. I'll ask Mr. Szwarcman to answer that question.

Mr. SZWARCMAN. Yes, thank you. We use approximately six national firms to perform brokerage and/or consulting services related to real estate acquisitions and/or leases.

Mr. JOHNSON. How much of that is the VA qualified to do internally?

Mr. SZWARCMAN. I believe that VA is qualified to do most of that activity internally. The issue, however, being resources.

Mr. JOHNSON. What's the cost of the brokerage fee to these firms?

Mr. SZWARCMAN. The brokerage fee is dependent upon a case-by-case basis. The contracts call for a maximum of a 3 percent commission that's to be paid by the lessor. It's—I don't know what the percentages are, Mr. Chairman, but I would say at least 50 percent of the times we negotiate a percentage that is significantly lower than 3 percent.

Mr. JOHNSON. Approximately how much does the VA pay annually to these firms for services such as this?

Mr. SZWARCMAN. I believe the answer is zero.

Mr. JOHNSON. Well then the Federal Government would be accepting a gift, which is illegal. So . . .

Mr. SZWARCMAN. I believe that this is an indefinite quality contract that is based solely on brokerage commission.

Mr. JOHNSON. But——

Mr. SZWARCMAN. Now, when we do consulting services through these brokerage firms as we sometimes do, we do have the option and do pay them on an hourly or task basis.

Mr. JOHNSON. So again, then how much annually do you pay?

Mr. SZWARCMAN. I don't have that figure right now, but I can take it for the record, it will depend on how——

Mr. JOHNSON. Please. I would appreciate——

Mr. SZWARCMAN [continuing]. Many tasks we have asked.

Mr. JOHNSON. Yeah. I'd appreciate it if you'd get that back.

What are the specific services that these brokers provide?

Mr. SZWARCMAN. The brokers will provide a variety of services including acquiring or commissioning for appraisals with us or other due diligence functions. Basically, things that are associated with our due diligence and/or procurement of real estate assets.

Mr. JOHNSON. Are these things that contracting officers could provide?

Mr. SZWARCMAN. Well, ultimately, the contracting officer is responsible for committing the government. The contractors, brokers,

and entities of that sort have absolutely no authority to commit the government.

Mr. JOHNSON. Wait a minute, say that again, I'm sorry.

Mr. SZWARCMAN. The brokers and/or contractors have absolutely no authority to commit the government. So basically any of the tasks that we assign to the contractors ultimately have to be reviewed by staff in-house, and ultimately the commitment of funds can only be done by VA employed FAC–C certified contracting officer.

Mr. JOHNSON. Okay. So back to the beginning of this series of questions, we've got services being performed by brokerage firms, from which you've acknowledged that most of those services could be performed by VA employees, contracting officers and such, correct?

Mr. SZWARCMAN. It's conceivable that most of those services could be provided by VA employees; however, there are a lot of talents and specific knowledge that the brokers bring to the real estate market.

Mr. JOHNSON. Then why are we paying for five brokerage firms, five or six, I think the number you said was about six, to perform work that VA employees are being paid to perform?

Mr. SZWARCMAN. Mr. Chairman, I think that the brokers are really utilized more in the sense of assisting us with a national program to essentially provide us with local expertise whether it's through market surveys or through other types of real estate related functions that sitting in Washington in central office, our staff my not have the best up-to-date knowledge.

Mr. JOHNSON. Well, in the VA's testimony regarding the two step process for larger leases, specifically it talks about a market survey team of VA employees with experience in different fields.

So I find it hard to believe that there's that much experience that brokerage firms are bringing to the table that a market survey team of VA employees with experience in different fields would not be bringing to bear. It seems to me like we're paying taxpayer dollars irresponsibly for services.

Mr. SZWARCMAN. Sir, the way our two step process works, is that before we initiate any of our lease actions specifically the two step type lease actions, what we would do is we would task the broker to survey the market area and see what is generally available in the market.

Based on that information, what we do then is we issue an advertisement in the Commerce—in the FedBizOp, along with the local newspapers. And after we get replies from specific interested parties, who may have land for sale, it is at that time that we get together a VA internal market survey team, and that team goes out and looks and evaluates each specific site that is under consideration.

The broker's function in that instance is largely that of making a determination what's available, what are the prospects, how much land, how many parcels are listed on the market currently. So that we know we're basically in the right area. And we also use that information to establish our delineated area by which we will advertise for interest.

Mr. JOHNSON. Okay. I think I've consumed the beginning of a second round already, so I'm going to yield to my colleague, Mr. Barrow.

Mr. BARROW. Thank you, Chairman. No, you're the Chairman, go right ahead.

I want to get a better idea than I have at present of the role that this Charleston VA facility had in both the initial proposal and in the upgrade, the decision to increase the size of the facility.

How would you compare and contrast Charleston's VA's input into each of those two decisions, both the initial proposal and the decision to enhance?

Mr. NEARY. Assuming that Charleston was the parent facility at the time, and I think that they were, they would have been the initiator of the original proposal, would have been reviewed by their veteran service—veteran integrated service network, the supervisory chain of command and come forward to the Washington central office for consideration.

Then the Charleston facility would have also recognized and come forward with their proposal to expand the size of the planned clinic, based on the veteran population or veteran users that are going to be coming to VA growing, and their proposal to increase some of the services that would be provided, so.

Mr. BARROW. Yeah, I want to parse the difference between those two, increase in the number of patients, of customers on the one hand, and the increase in the number and variety of services being provided on the other.

Because first off, I commend y'all for trying to make services available as and when needed, and to expand the range of services available. I just wanted to distinguish between those two in this case.

Because in 2009, if I understand correctly, when the decision was made to expand the facility in Savannah, the patient workload was actually projected to go down over time, the figures that we've been provided, saying that in 2009 VA's estimate of the patient population, the veteran population in the area covered by the Savannah was going to go from 56,250 in 2005 to an estimated 47,940 in 2015, to a projected 43,057 in 2025. So there's a steady decrease in the number of patients.

And yet, also I understand that the services that can be provided at the CBOC are going to be much more expansive, it's going to cover not just an increase in workload but mental health services, optometry, audiology, radiology, new physical security requirements, the PACT initiative, all of that stuff was going to be added to what's available at the Savannah.

Am I correct in understanding that that's the nature of the service, the level of service that was going to be expanded to there?

Ms. FATE. Yes, sir, that's correct.

Mr. BARROW. So how much of the increase in the square footage and the size of the physical facility there is attributable to the increase in services, as opposed to the increase in the number of patients?

Ms. FATE. We can get you that specific information.

Mr. BARROW. It looks like it's going to be all of it because it's looks like a projected decrease in the number of patients.

Ms. FATE. Well, there was a projected decrease in the number of patients, that's correct; however, it was always an increase in the projected workload demand. And so every unique has its own workload and the services that we can expect for every veteran.

And so while it was projected to go down back then when the original submission came in, the projected ambulatory stops for primary care and specialty was planned to increase by 92 percent.

And so just for those services that were going to be included in the original submission, and subsequent to then, based on projected workload models that have been updated since that time, the projections increased even 30 percent more for just those same services for primary care, as well as mental health.

Mr. BARROW. Again, this is something I think we want to commend, and we want to support in every way we can. I'm going to put in another plug, though, for the idea of directing folks in Savannah up to Augusta. It's a whole lot easier drive. It's a real hard slog to get from Savannah to Charleston. You can ask General Sherman what it was like.

It's not that much easier today than it was back then. Thank you very much. I yield back.

Mr. JOHNSON. I thank the gentleman for yielding back. For clarification purposes, VA leases are paid from the medical facilities account, correct?

Mr. NEARY. Yes, sir, that's correct.

Mr. JOHNSON. In the FY 2013 budget submission and prior submissions, VA includes a prospectus on each major medical facility lease for which it is requesting congressional authorization. The prospectus also includes what appears to be an appropriation request which tracks the authorization request. For FY 2013, the total request for all leases is 103 million.

Does the FY 2013 appropriations request for medical facilities include the 103 million for the lease authorizations?

Mr. NEARY. Ms. Fate.

Ms. FATE. Thank you, sir. While the prospectus provides the authorization request, the appropriation for these major leases is managed at a more aggregate level. And so we do not have specific appropriation for leases like we would for our major construction projects.

Mr. JOHNSON. But is that 103 million included in that aggregate?

Ms. FATE. Well, the—according to the prospectus where the schedule shows for these leases, they plan to be awarded in 2014 for all of these leases. And so the budget appropriation request that requests for the 2014 would include those leases, not for the 2013. The 2013 includes leases that are currently ongoing, as well as any—the new ones that we have coming online that would be obligated in requiring 2013 funds.

Mr. JOHNSON. Okay. What is the—what are the updated demographic data that the VA used to go from 38,900 square feet up to 55,193 in Savannah and from 70,600 up to 161,525 square feet in Green Bay?

Ms. FATE. Well, for—sir, for Green Bay, we're going to have to take for the record and get back to you.

For the demographics that we anticipate for the workload projections, we only have the projected workload and the projected work-

load going from the most updated 2010 base line of 43,000, in the next 10 years, increases 31 percent, just for the ambulatory and mental health care stops, to be projected for the Savannah clinic.

Mr. JOHNSON. Is that—are those services that you're not performing today?

Ms. FATE. No. We are performing services either at the parent facility or at the Savannah facility.

Mr. JOHNSON. How can you have that big of an increase in services provided when you've got a 23 percent decline in population? How—I'm having trouble making the connection.

You say you're providing the services today, and yet you see a 23 percent decline in population. How is the workload going to go up that much, that's going to require nearly a—looks like a 17,000 addition to the original estimate?

Ms. FATE. And again, that is for over a 10 year period, so we don't—we won't see it in 2012 or '13 per se, but we would see it in the next 10 years.

It's based on our actuarial model and assumptions made when the planning horizon for the next 10 to 20 years. And so we can get you—what the assumptions were that were loaded into the model to provide our actuarial results.

Mr. JOHNSON. Can you get us that? That's some of the kind of information that would go into a detailed cost benefit analysis.

Does the contract for Savannah include the local tax breaks associated with a Federal building?

Mr. SZWARCMAN. I'm sorry, Mr. Chairman, it does not.

Mr. JOHNSON. Okay. Does the projected VA lease in Savannah include utilities?

Mr. SZWARCMAN. The projected lease amount is an unserviced amount that we are quoting, so the answer is no.

Mr. JOHNSON. What is the projected size of the new VA clinic in Savannah and the best estimate of the total lease cost over 20 years for the new project?

Mr. NEARY. We are in the middle of the negotiation and the procurement phase with proposers, so it would be inappropriate for me to state here on the record, sir, what we think the price will be. But I can say that it will approach $2 million per year.

Mr. JOHNSON. Can you take that back and confirm it?

Mr. NEARY. I certainly can.

Mr. JOHNSON. Okay. Thank you. Another item that could've been or might've been included in a detailed cost benefit analysis is some of the alternatives to expansion. Why isn't the VA simply expanding the clinic's hours to more effectively use the existing capital investment like the private sector does before making new capital investments?

Mr. NEARY. In this case, we entered into a lease for the current facility for 20 years, that's the maximum authority that the Department has. In order to continue on in that building should we have chosen to do so, it would need to be reacquired through a competitive procurement.

I think I mentioned earlier that it would be very difficult to expand and modernize that building while the clinic continued to operate.

Mr. JOHNSON. That's not the question. The question was, why not expand—Ms. Fate talked about the need for increased service workload. Why not expand the hours that the service providers work, rather than expanding the physical facility?

Mr. NEARY. You want to comment on it?

Ms. FATE. Thank you, sir. I'll try and attempt to answer that. The—we're not certain—I mean, I'm not certain whether or not the clinic has expanded hours right now or whether or not it was—we can take that for the record. I know that's an initiative that we're looking at across the country to ensure that we're expanding hours where it's viable.

Mr. JOHNSON. Yeah. The——

Mr. NEARY. Mr. Chairman, if I could add, the fact that our lease is expiring and we don't have the authority to be in the building does impact the concept of expanded hours. As Ms. Fate said, many VA facilities are using expanding hours to accommodate workload, but in this case, we need to find another facility or a new lease to function.

Mr. JOHNSON. Aren't you already—isn't that facility already on a succeeding lease?

Mr. NEARY. We're on a——

Mr. JOHNSON. From the original?

Mr. NEARY. We are on a succeeding lease, to permit us to continue in operation while the new space is acquired, yes, sir.

Mr. JOHNSON. Okay. I'll yield to my colleague, Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chairman.

Just to sum up, if I understand today's testimony, that Charleston initiated a request for an expansion of the Savannah CBOC beyond what had been previously authorized by Congress, correct?

Mr. NEARY. That is correct, sir.

Mr. BARROW. There is no formal process for coming to Congress to request an increase in the authorization. If I understand what happens, the VA decides whether or not to grant Charleston's request based on the resources that are already otherwise available to the VA without coming to Congress to ask for an increase in congressional authority; is that correct?

Mr. NEARY. We are required to come to the Congress and notify the Veterans' Affairs Committees of our intent to expand if that expansion is greater than 10 percent of what was authorized.

Mr. BARROW. And did that happen in this case?

Mr. NEARY. That has not happened yet. We're in the process of preparing to do that, and would intend to do that once we've resolved the issue associated with the erroneous appraisal.

Mr. BARROW. And as has been previously established, because of the timing of this, it is possible for resources to be lost if the authorization isn't granted?

Mr. NEARY. I'm sorry, if the authorization were not granted?

Mr. BARROW. Yes, sir.

Mr. NEARY. If we were to make a decision to walk away from this site, we would lose the resources that we've committed and acquire in the purchase option—the transferrable purchase option.

Mr. BARROW. Likewise, if Congress decided not to authorize the expansion by the time y'all finally come back to ask for it, then that's another way in which y'all would walk away from it because

Congress wouldn't authorize it. Nonetheless, it would be a loss incurred along the way.

Mr. NEARY. That's a possibility.

Mr. BARROW. Okay. All right. You can agree, can you not, that there's a greater need for enhanced communication between the VA when its acting at the initiative of one of its medical facilities, and the body that represents the taxpayers, trying to make sure that all the resources are being allocated on a fair and equitable basis and reach as many people as possible, and with a minimum potential for loss along the way. You'll agree with that, won't you?

Mr. NEARY. I can agree with that, sir, yes.

Mr. BARROW. Okay. Well, I hope we can achieve that. Thank you very much.

Mr. JOHNSON. I thank the gentleman for yielding back. I want to go back to the fact that you're on a succeeding lease now, and I think if I understood you and you correct me if I'm wrong, you stated that expanding the current facility is not an option?

Mr. NEARY. We believe that to be the case, yes, sir.

Mr. JOHNSON. How do you know that? Have you asked the current lessor whether they can expand that facility?

Mr. NEARY. We did, and as I understand it, members of my staff met with the current lessor and their technical advisors, and they were—in that discussion, the lessors' advisers discussed the difficulties and I'm told, stated that that building could not be modernized to meet VA's current requirement.

Mr. JOHNSON. Interesting. That's what the lessor said, that it could not be modified to meet the current requirement?

Mr. NEARY. It's my understanding the lessors' advisers, not necessarily the lessor.

Mr. JOHNSON. Because that's contrary to the information that we've got. And see that again, if I look at the—that's the kind of information that I would expect to find in a cost benefit analysis, Mr. Neary. But if I read your cost benefit analysis, I don't see an alternative of expansion to the current lease facility in your cost benefit analysis. That's one of the many things about this that causes me concern.

Let's move to the appraisal process. Who is at fault for the initial contract with the uncertified unqualified appraiser for the Savannah site?

Mr. NEARY. The appraisal company that performed the appraisal and the individual that performed the appraisal is certified, and appropriately licensed, notwithstanding that, they made an error in conducting that appraisal.

Mr. JOHNSON. The initial appraiser?

Mr. NEARY. The initial—the appraisal that had the error in it that the Committee identified for us, yes, sir.

Mr. JOHNSON. The initial appraiser for the—you're saying was performed by a qualified certified appraiser?

Mr. NEARY. Yes, sir.

Mr. JOHNSON. Okay. That's your testimony?

Mr. NEARY. Sir, obviously if the Committee has——

Mr. JOHNSON. That's contrary to what we're finding.

How much did that initial appraisal cost, and how much was the appraiser paid?

Mr. NEARY. Sir, we'll have to find out and provide that for the record.

Mr. JOHNSON. Please. Okay. Well, seeing that there are no further questions, I have no further questions.

I want to thank the panel for being here today, and you are now excused.

The issues discussed here today were yet another example of this Committee's efforts to reach out to the VA with founded concerns in an attempt to quickly and easily resolve them.

The dismissive response from VA Congressional Affairs makes it appear that the VA does not desire a cooperative relationship in solving these problems. Now, I heard my colleague as the question, could communication be improved, your response was yes.

I too hope that we could get to that point, and I hope that we can move forward together to solve these problems and others.

I want to again mention that today's hearing topic is not limited to Savannah. We know these actions are occurring in other locations, and today's discussion is a case study of this national issue.

With that, I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material.

Without objection so ordered.

I want to thank all members and witnesses for their participation in today's hearing and business meeting. This hearing is now adjourned.

[Whereupon, at 1:00 p.m. the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bill Johnson, Chairman

Good morning. This hearing will come to order.

I want to welcome everyone to today's hearing on the VA'S Dubious Contracting Practices: Savannah.

As this Subcommittee made clear to the VA in its invitation to this hearing, we are examining the proposed clinic in Savannah as a case study for the rest of the country. We have evidence of similar dubious practices taking place at other locations, and our intent is to have the VA fix the problems and conduct necessary oversight at all of its construction sites.

The problematic practices referred to in today's hearing title have to do with the VA exceeding the size and scope of requested authorizations, conducting haphazard due diligence, and not being forthcoming about its actions to Congress.

In fact, this Subcommittee contacted the VA last year with several specific concerns about this site in Savannah with the hopes of helping the VA conduct better business. The response was disheartening: despite the specific concerns cited, the VA dismissed the Subcommittee's efforts to reach out and work together, instead giving a cursory response.

When the VA selects a site, such as Savannah, and requests a specific authorization from this Committee, it is reasonable to expect that the VA intends to move forward toward those goals. As is the case with Savannah and many other sites around the country, the VA's actions have not matched its words.

In its Fiscal Year 2013 budget request, the VA claims to use "the best infrastructure planning practices from both the private and public sectors to integrate all capital investment planning . . . " It is my hope that today's discussion elaborates on those best practices the VA says it uses as well as best practices that it declines to use.

The VA's Fiscal Year 2009 budget request includes an authorization request of over three million dollars for expansion of its Savannah CBOC with an annual rent of over a million dollars. The Fiscal Year 2013 request includes the same authorization amount and the same net usable square feet for what the VA refers to as a "satellite outpatient clinic." On the surface, things appear to be the same.

However, in 2009, the VA issued a request for a proposal for nine to twelve acres in Savannah that could accommodate constructing an outpatient clinic. The difference between what the VA had proposed to Congress less than a year earlier and what it was moving forward with in the community was significant. Among the alternatives submitted in its fiscal year 2009 budget submission to Congress, the VA stated that constructing an outpatient clinic "burdens VA with additional owned infrastructure." Conversely, a November 2010 letter from Glenn Haggstrom, the VA's Executive Director for Acquisition, Logistics, and Construction, can't say enough good things about the VA building new construction.

Notwithstanding the lack of communication with Congress, the VA also stumbled through its acquisition process, using an incomplete and careless appraisal process that according to many involved in commercial real estate lacks common sense. To veterans, taxpayers, and Congress, the resulting concern is that the VA is failing to get the best value.

Based off the original FY 2009 budget request, the "expanded" Savannah clinic would be occupied in June 2011. In the most recent budget request submitted just a few weeks ago, the status is listed as 'acquisition process initiated.' As I mentioned earlier, this is not an isolated incident, and the veterans in need of services are the ones being harmed by delays, cost overruns, and failure to thoroughly analyze costs and benefits associated with every alternative.

I look forward to an honest discussion today on the VA's methodology, including mistakes and missteps. I further hope to hear solutions that can bring veterans in Savannah and throughout the country a timely delivery of health care services at the best value.

I now recognize the Ranking Member for an opening statement.

I would now like to welcome the panel to the witness table. On this panel, we will hear from Robert Neary, Acting Executive Director of the Office of Construction and Facilities Management at the Department of Veterans Affairs. He is accompanied by George Szwarcman, Director of Real Property Services at the Department of Veterans Affairs, and Brandi Fate, Director of Capital Asset Management and Support in the Veterans Health Administration.

Our thanks to the panel. You are now excused.

The issues discussed today were yet another example of this Committee's efforts to reach out to the VA with founded concerns in an attempt to quickly and easily resolve them. The dismissive response from VA Congressional Affairs makes it appear that the VA does not desire a cooperative relationship in solving problems. I hope this is not the case, and that we can move forward together to solve these problems and others.

I want to again mention that today's hearing topic is not limited to Savannah. We know these actions are occurring in other locations, and today's discussion is a case study of this national issue.

With that, I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material.

Without objection so ordered.

I want to thank all members and witnesses for their participation in today's hearing.

This hearing is now adjourned.

Prepared Statement of Hon. Joe Donnelly,
Ranking Democratic Member

Today's hearing will explore, in detail, issues surrounding the major medical facility lease for expanding the community-based outpatient clinic in Savannah, Georgia. By closely looking at one such facility, we will also get a clear picture of how this vital program is currently operating.

Beginning with last year's budget submission, the VA's construction and leasing decisions are made under the VA's Strategic Capital Investment Planning (SCIP) process. Lease projects are an important component of the VA's effort to modernize its health care delivery system and provide greater access to our veterans. Because of its importance for the provision of quality health care, it is essential that the lease process be as quick, fair, and transparent as possible. This includes keeping Congress informed of important decisions and making sure that taxpayer dollars are spent as wisely as possible.

The VA sought congressional authorization for the Savannah, Georgia clinic expansion in its FY 2009 budget submission. This authority, for a clinic with 38,900 net usable square feet at a cost of $3.2 million, was provided in October, 2008. Sometime after this authorization, the VA expanded the project by over 45 percent, and is now seeking to lease a clinic with a maximum net usable square footage of 55,193. The VA has not notified Congress or sought additional authorization for this expansion. In addition, although this project was authorized in 2008, construction is just now going forward.

The clinic in Savannah is not the only project which the VA has expanded after seeking authorization. Projects in Atlanta, Georgia, Eugene, Oregon, Fayetteville, North Carolina, Grand Rapids, Michigan, Green Bay, Wisconsin, and Greenville, North Carolina are all slated to be substantially larger than authorized by Congress.

In addition to exploring how and why VA feels it has the authority to move forward on projects with a larger scope than authorized, I am hopeful that we will get a better idea as to why these projects take so many years to complete from initial authorization to the doors being opened to serve veterans.

I look forward to hearing from our witnesses and getting a better understanding how the lease program operates, as well as exploring possible changes to the program that may be necessary to ensure that VA and Congress are working together and that the process from identifying leasing opportunities up to the ribbon-cutting ceremonies is fair, fast, and economical.

Prepared Statement of Robert L Neary

Chairman Johnson, Ranking Member Donnelly and Members of the Subcommittee, I appreciate the opportunity to testify on the Department of Veterans Affairs (VA) contracting practices for leasing and specifically on the Savannah, Georgia, Outpatient Clinic (OPC) lease procurement as a case study. My testimony will outline the lease process/procurement used by VA as well as address the reasons for the changes required in the procurement of space for the Savannah OPC.

Savannah Appraisal

I would like to update information VA previously provided to the Committee.

In response to a series of questions from the Subcommittee in December 2011, VA provided an incorrect appraisal for the targeted relocated Savannah Outpatient Clinic site. Instead of referencing a 46.85 acre site, VA inadvertently referenced a 16.85 acre location. The appraiser failed to identify that the deed of sale and the tax records did not reflect the same information.

Since learning of the discrepancy, VA immediately requested a revised appraisal and provided an update to the Subcommittee on March 2, 2012, acknowledging the error. VA is contracting for another certified appraiser to review the initial appraisal, and provide a determination regarding fair market value of VA's preferred site as of Spring, 2010. Finally, VA is also obtaining a new appraisal that reflects the current land value of the site. VA will review all the appraisal reports concerning the targeted parcel in Savannah in order to determine what appropriate corrective action may be warranted.

I want to emphasize that VA only uses appraisers who maintain appropriate licensure and accreditation, in addition to adherence to the Uniform Appraisal Standards for Federal Land Acquisitions, which is standard operating procedure.

I would like to apologize to the Committee for the delay in uncovering the facts and provide assurance that responses to future inquiries will be more thoroughly investigated.

General Leasing Information

Acquisition of space through lease is an important component to ensure that VA has adequate health care facilities to serve our Nation's Veterans. VA currently leases approximately 13.4 million square feet in support of the health care system.

Beginning with the fiscal year (FY) 2012 budget cycle, decisions on whether to move forward with a lease project are an outcome of VA's Strategic Capital Investment Planning (SCIP) process. When analyzing lease projects, SCIP considers several factors, including facility and access requirements, availability of existing facilities and space, safety and security needs, and cost. Lease project submissions include the completion of an Office and Management and Budget (OMB) exhibit 300, in accordance with OMB Circular A–11, Part 7. The OMB–300 includes a cost benefit analysis of potential solutions, including evaluation of maintaining the status quo, constructing new space, and leasing. The information enables VA to determine how to best use available resources for capital investments.

There are specific approval thresholds for the acquisition of SCIP-approved facilities through lease. A lease with an annual rent over $1,000,000 requires specific congressional authorization under 38 U.S.C. § 8104(a)2. Smaller leases, with an annual rent between $300,000 and $1,000,000, require approval by the Secretary of Veterans Affairs. Leases exceeding 10,000 square feet with annual rent under $300,000 require approval by the Executive Director, Office of Construction and Facilities Management. Leases that are less than 10,000 square feet, under $300,000 in annual rent, and a 10 year term or less, are delegated to the Veterans Integrated Services Networks for approval.

The lease acquisition process is typically conducted as a best value competition, and is always in accordance with the Competition in Contracting Act, the General Services Administration Acquisition Regulation, and other applicable laws and executive orders. The best value process awards projects to the contractor that best meets a combination of price and technical qualifications. Technical qualification criteria are identified in the Solicitation for Offers (SFO), and are evaluated by a team of qualified professionals, including architects and engineers. The price component of an offer is also evaluated by qualified professionals, including technical and contacting staff. This method results in performance-based accountability, as well as a full and fair competition.

For large leases, VA prefers to use a two-step process for obtaining a built-to-suit lease-based medical facility. Step one is obtaining an assignable option to purchase a suitable site, and step two is competitively procuring a developer. Step one is initi-

ated by VA determining a delineated geographic area and issuing an advertisement for sites. The preferred site is competitively selected by a market survey team composed of VA employees with experience in various disciplines such as real property, engineering, environmental issues, and clinical or program management. The market survey team uses a standard set of criteria that includes an array of factors such as evaluation of the surrounding area, accessibility, availability of utilities and amenities, and the natural conditions of the site.

As part of step one, VA is also required to conduct certain due diligence activities in the areas of real estate, including a title report, survey, geotechnical survey and appraisal; and comply with the National Environmental Policy Act (NEPA), the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA); and Section 106 of the National Historic Preservation Act (NHPA). During this stage, VA also conducts negotiations with the landowners, based on the appraised determination of fair market value, in order to reach a purchase price. Once a price is agreed upon, VA and the landowner execute an assignable option to purchase the site. This option is later assigned from VA to the developer selected in step two. When all of the due diligence requirements are satisfied, the assignable option and all due diligence documentation become part of the SFO package in step two.

Step two is the competitive procurement seeking a developer to purchase the land identified in step one, and build the facility to VA specifications. Wide competition is sought during the procurement process to ensure reasonable rental rates. VA works with an Architectural/Engineering firm and the local VA users to determine the specific technical requirements of the clinic. These requirements are made available to the potential offerors in the SFO. The offerors are typically allotted 45 days to submit their offers to VA. Once the offers are received, VA establishes a Technical Evaluation Board (TEB), which evaluates each offer by a set of pre-determined criteria. VA also conducts a price evaluation. Based on these evaluations, VA establishes a competitive range of offerors, negotiates with the offerors within the range, and requests Final Proposal Revisions from those offerors. The TEB is then reconvened to review any new technical data before the Contracting Officer determines which offer presents the best value to the government. The lease is then processed for award.

Savannah OPC Information

The current lease of 34,760 square feet for the Savannah OPC was activated in September 1991. Because the existing lease was due to expire in 2011, and due to the growing demand for health care services, VA determined that a new lease for the Savannah OPC was required. Current lease action for the Savannah OPC began at that time, and preceded use of the SCIP process. The original lease expired in 2011; however, VA continues to occupy this space through a succeeding lease executed in July 2011. This was necessary to maintain operations until a new space is procured and activated.

In FY 2009, Congress authorized $3,168,000 for a new 38,900 square feet OPC in Savannah, Georgia. The $3,168,000 includes $1,029,000 for the first year's rent, plus a one-time lump sum payment of $2,139,000 for special purpose medically-related improvements.

The original requirement called for 38,900 square feet of space for the Savannah OPC. However, in 2009, the Charleston VA Medical Center, Savannah's parent facility, raised its request to 55,000 square feet, based on an increased projection in workload, the need for enhanced mental health services, the addition of optometry, audiology, and radiology services, new physical security requirements, and the need to support and implement VA's new Patient Aligned Care Teams (PACT) initiative at all sites. This updated scope was based on an evaluation of current workload data and seems to be a reasonable solution to provided needed medical care to Veterans in the Savannah area. The updated scope is reflected in VA's current SFO.

PACT provides accessible, coordinated, comprehensive, patient-centered care, and is managed by primary care providers with the active involvement of other clinical and non-clinical staff. PACT allows patients to have a more active role in their health care and is anticipated to be associated with increased quality and patient satisfaction, and may lead to a decrease in hospital costs due to fewer hospital visits and readmissions. It also calls for the delivery of a full complement of mental health services, such as compensated work therapy and mental health intensive care management.

VA received proposals in November 2011, based on the updated space requirements. The current market-based pricing indicates a cost that exceeds by more than

10 percent, the amount authorized by Congress in FY 2009. Accordingly, per 38 U.S.C.

§ 8104(c), VA must now submit a notice to the Committees on Veterans' Affairs of VA's intent to proceed with the lease contract. VA is in the process of finalizing the notice, and intends to award a lease contract. In addition to the increase in size, the increase in rent takes into account VA's increased environmental sustainability and physical security requirements, which were updated since the preparation of the original authorization request. Barring any unforeseen circumstances, VA expects to award this lease in June 2012, complete construction in June 2014, and activate for service shortly thereafter.

In closing, we look forward to the completion of the facility and to providing care to Veterans in Savannah, Georgia.

I look forward to answering any questions the Committee has regarding the Savannah CBOC expansion.

MATERIAL SUBMITTED FOR THE RECORD

Post-hearing Questions and Responses for the Record:

Hon. Bill Johnson, Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, to Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs

MARCH 16, 2012

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

I request your response to the enclosed questions for the record I am submitting in reference to the Oversight and Investigations Subcommittee hearing entitled "VA's Dubious Contracting Practices: Savannah" that took place on March 9, 2012. I would appreciate if you could answer the enclosed hearing questions by the close of business on April 27, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Bernadine Dotson at *Bernadine.dotson@mail.house.gov*. If you have any questions, please call Eric Hannel, Majority Staff Director of the Oversight & Investigations Subcommittee, at 202–225–3527.

Sincerely,

Bill Johnson
Chairman
Subcommittee on Oversight & Investigations

BJ/rm

1. Based on Lease proposals currently being evaluated for award in Savannah, what is the fee that the Lessors will be required to pay to Public Properties, L.L.C., for the proposed new Savannah Clinic?
2. Including a reasonable return on capital and financing costs, how much of the total lease costs to be paid by VA will be to compensate the Lessor for payment of the Lease Acquisition Fee? For that sum, how many additional VA Contracting Officers could be employed to provide the same service?
3. If VA followed the Congressional Authorization Limits for the Savannah Clinic, negotiated directly with the existing Lessor for expansion of existing space and adhered to the Lease Cost budget approved by Congress, how much would the lease acquisition fee potentially paid to Public Properties, L.L.C., be?
4. Why isn't VA expanding the current Savannah, GA, clinic's hours to more effectually use the existing capital investment, like the private sector does, before making new capital investments?
5. What were the 2011 use statistics in Savannah or clinic stops? VA projected current use would increase 85 percent in 10 years—how much has it increased in 6 years? What does VA project impact on Service needs in Savannah will be when the new 23,348 square-foot clinic in Hinesville, GA, is completed?
6. What are the demographic statistics for Hinesville, GA, and Savannah, GA?
7. What is the updated demographic data VA used to go from building a 70,600 square-foot facility up to a 161,525 square-foot facility in Green Bay, Wisconsin?
8. How does the new proposed site in Savannah's accessibility to public transportation compare to the existing site's accessibility?
9. An expansion of the Savannah clinic was authorized in fiscal year 2009, the current facility's lease expired in 2011, and VA is now on a succeeding lease. When does VA anticipate a veteran will be able to step foot inside a new Savannah clinic?

10. Will VA recover the costs for the initial unqualified appraisal? If so, from whom?
11. Did the unqualified appraiser break the law?

U.S. Department of Veterans Affairs Responses, August 9, 2012
Questions for the Record Submitted by
Chairman Bill Johnson
Subcommittee on Oversight and Investigations
House Committte on Veterans' Affairs
"VA's Dubious Contracting Practices: Savannah"
March 9, 2012

Question 1: Based on Lease proposals currently being evaluated for award in Savannah, what is the fee that the Lessors will be required to pay to Public Properties, L.L.C., for the proposed new Savannah Clinic?

VA Response: The broker will obtain a commission of 2 percent of the total contract value over the lease term. The actual fee will be based on the cost of the lease, as proposed by the successful offeror.

Question 2: Including a reasonable return on capital and financing costs, how much of the total lease costs to be paid by VA will be to compensate the Lessor for payment of the Lease Acquisition Fee? For that sum, how many additional VA Contracting Officers could be employed to provide the same service?

VA Response: The brokerage commission earned by commercial firms under a VA indefinite delivery/indefinite quantity (IDIQ) contract does not affect the fair market value of the lease cost. While all commercial developers, including VA's lessor, include project soft costs and broker commissions into the total project cost, VA will only pay the fair market value rental rate to the successful offeror that is based on the competitive offers and independently verified by an appraisal prior to contract award. Specifically, the cost VA is paying on a per square foot basis, regardless of the costs incurred by the lessor, will be confirmed as reasonable and supported within the commercial real estate market prior to award. VA commissions an appraisal to confirm the rental stream is fair and reasonable prior to award, as well as performing an internal verification to ensure the rental rate is reasonable and supported by the market pricing, in consideration of the local market values, the size and complexity of a major medical facility, and VA's specific physical security and sustainability standards.

Regardless of the composition of each individual lessor's individual financing, profit-margins and sub-contractor agreements, VA will not award to a lessor whose rental rate exceeds market value.

It is important to note that the broker commission in the Savannah area averages 6 percent as the industry standard and is typically split between the listing and procurement brokers. The broker commission is inherently built into the market value of properties within the commercial real estate market. VA negotiates each percentage on a project by project basis with the selected IDIQ firm, and under VA's contract with the IDIQ brokers, in no event will the commission authorized by VA exceed 3 percent, regardless if the market conditions in the private sector would support a higher rate. In this case VA negotiated a rate of 2 percent with the selected IDIQ contract broker.

Question 3: If VA followed the Congressional Authorization Limits for the Savannah Clinic, negotiated directly with the existing Lessor for expansion of existing space and adhered to the Lease Cost budget approved by Congress, how much would the lease acquisition fee potentially paid to Public Properties, L.L.C., be?

VA Response: VA does not have the option of negotiating directly with the current lessor without conducting a full and open competitive procurement.

At the time VA requested congressional authorization, the 20-year term of the current lease was set to expire in April 2011. In a lease-procurement, VA's authority is limited to 20 years, and after that period VA must conduct another procurement to obtain leased space. As a result, VA initiated a full and open competitive procurement in accordance with the Competition in Contracting Act (CICA), in order to align delivery of new space needs and requirements to support the modern delivery of health care services within limitations of its statutory leasing authority.

In 2009, prior to seeking solicitations for a new lease procurement, VA determined that a clinic of over 50,000 net usable square feet would be required in order to meet the needs of the Veteran patient population within the catchment area. Pursuant to the CICA, 40 U.S.C. §§ 3301, *et seq.,* VA, as a Federal agency, is required to obtain full and open competition through the use of competitive procedures that are best suited under the circumstances of the procurement. (41 U.S.C. § 3301(a)). VA determined that there was extremely limited competition for existing space within the catchment area for a large medical facility. A build-to-suit facility would fulfill Federal contracting requirements to allow for sufficient competition as well as provide Veteran patients with a modern health care facility, assist VA staff in providing patients a high quality of health care, as well as meet various Federal sustainability and physical security requirements. VA also met with the existing clinic lessor and his representatives, and the lessor's representative stated that the existing facility would require significant infrastructure upgrades to meet current physical security and sustainability requirements (i.e., significant upgrades and replacement of plumbing, mechanical, electrical, and structural elements).

In light of Federal contracting requirements, the expiration of the 20-year lease contract, higher modern standards for VA facilities regarding sustainability and physical security, and the growing needs of the Veteran patient population, directly negotiating with the lessor to expand in place was not a viable option.

Question 4: Why isn't VA expanding the current Savannah, GA, clinic's hours to more effectually use the existing capital investment, like the private sector does, before making new capital investments?

VA Response: Charleston VA Medical Center (VAMC) has previously explored alternative hours of operation (i.e., extended hours during the week and weekend operations) and Veterans' responses have been mixed. A recent survey of 432 Veterans who receive care at the Charleston VAMC, and its outlying clinics found that 52 percent would not be interested in coming in for care during extended hours or on weekends. Of the 48 percent who were in favor, 36 percent had no preference and only 8 percent and 4 percent, respectively identified weekends and evenings as preferences.

Question 5: What were the 2011 use statistics in Savannah or clinic stops? VA projected current use would increase 85 percent in 10 years—how much has it increased in 6 years? What does VA project impact on Service needs in Savannah will be when the new 23,348 square-foot clinic in Hinesville, GA, is completed?

VA Response: [1]

Savannah Outpatient Clinic	FY 2006	FY 2011	Variance
Visits	50,754	74,130	+ 23,376 (46%)
Unique Veterans	8,173	11,026	+ 2,853 (35%)

Savannah Outpatient Clinic	FY 2012—thru March (2nd Q)	6-year average growth rate	Preliminary End-of-Year FY 2012 Projection
Visits	38,493	8%	80,060
Unique Veterans	8,708	6%	11,688

At present, the Hinesville lease is projected to activate before the replacement Savannah lease. Award for Hinesville is projected to be August 2012 with activation averaging 18–24 months thereafter. Award for Savannah is still pending. Veterans Integrated Service Network (VISN) 7 and Charleston VAMC discussed projected migration and reassignment of Veterans from the Hinesville and Savannah surrounding counties in developing the space plans for both leases.

The temporary clinic in Hinesville has already realized migration of Veterans from other sites of care including the Brunswick Community-Based Outpatient Clinic (CBOC) and the Dublin VAMC. The Hinesville CBOC is also projected to increase collaboration with nearby Fort Stewart/Winn Army Hospital for VA and Department of Defense (DoD) sharing activities. Data is based on fiscal year (FY) 2012 (thru 2nd Quarter) workload obtained from VISN Support Service Center.

[1] Data Source: VISN Support Service Center

Question 6: What are the demographic statistics for Hinesville, GA, and Savannah, GA?

VA Response: ***Hinesville***—The temporary CBOC was activated in July 2011 and will remain open until the permanent CBOC is activated. The workload for FY 2011 was approximately 1,200 visits, and the workload for FY 2012 (through 7/23/2012) is approximately 4,029 visits with 1,304 unique Veterans.

Clinical services at the temporary clinic include primary care and tele-mental health. These services will be expanded at the permanent CBOC to include optometry, general radiology, women's health, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), and very select outpatient specialty care.

This CBOC is located in direct proximity to Ft. Stewart/Winn Army Hospital and expanded VA/DoD collaboration and resource sharing is expected. A resource sharing agreement for telehealth was activated effective 2/3/2012 and allows Army Providers to focus more attention to Medical Hold cases. Further expansion of mental health and telehealth services will be discussed closer to activation of the expanded Hinesville CBOC.

Workload Factors Justifying Scope Revision

The scope of the CBOC Business Plan was revised based on several workload factors. The original CBOC Business Plan identified a projected annual workload of 20,029 visits (primary care and mental health only). The latest revised workload projections (including migration from other existing VA sites of care) identified 32,625 annual visits—an increase of 12,596 (63 percent increase).

- 11 percent increase in primary care
- 55 percent increase in mental health
- expanding radiology services (ultrasound and bone density)
- adding select specialty services not in original Business Plan

There are currently 145 women Veterans treated in Hinesville. Local projections identify a continued 8–10 percent annual projected increase in women Veterans.

Revised projections were based on a maximum capacity of 7,200 unique primary care patients:

Resulting Changes in Space Plan

The original space plan concept was 10,000 net usable square feet (NUSF). Due to future projected workload increases, Charleston VAMC did not want to activate an undersized clinic. Therefore, a revised space plan was submitted and approved for approximately 23,348 NUSF. The revised space plan will include a separate team for women's health and OEF/OIF/OND Veterans.

Savannah—the original lease was activated in 1991. The 2008 prospectus identified 39,196 NUSF in a new lease. The Charleston VAMC requested and received approval to increase the NUSF to 51,040 in 2009. The current design is at 55,193 NUSF, which is within the previously utilized agency reapproval threshold of 10 percent.

Workload Factors Justifying Scope Revision

The original workload from 2007 identified future projected workload of 55,465 visits.

Revised workload projections from 2008 identified an increase in total visits to 76,571 visits (increase of 38 percent).

The current workload figures used a total of approximately 72,160 visits. This includes factoring in estimates for migration of Veterans to Hinesville.

Future projections for the Savannah catchment area (2010 compared to 2030. Projections based on data obtained from ProClarity). ProClarity is a database identifying the latest VA Enrollee Health Care Projection Model for future utilization, enrollee, and veteran population projections.

- 20 percent decline in Veteran population
- 32 percent increase in enrollees
- 24 percent increase in market penetration

There are currently 1,440 women Veterans followed in Savannah. Local projections identify a continued 8–10 percent annual projected increase in women Veterans.

Resulting Changes in Space Plan

The original space plan identified 39,199 NUSF. Approval to increase space due to workload was received in 2009, and the revised space plan total was 51,040 NUSF.

Current space plan identifies 53,506 NUSF which is within the 10 percent limit. Largest clinical increases were in:

- Mental Health—2,850 NUSF
- Specialty Care—5,107 NUSF
- Radiology—1,307 NUSF

The rationale behind increasing select specialty care services was to meet increasing workload, and also to help decompress specialty care at Charleston VAMC. Select expansion includes:

- Mental Health—full benefit package for mental health services (required for sites of care with over 10,000 unique patients)
- Audiology
- Optometry
- Radiology (including CT Scanner, ultrasound, and bone density)

There are separate teams for women's care and OEF/OIF/OND in the current revised space plan.

These strategies will have the following positive effects:

- Decrease drive time to Charleston (approx. 100 miles) for select Veterans;
- Decrease travel pay for those Veterans who will receive expanded services in Savannah;
- Decrease fee basis expenditures in the Savannah area for select services; and
- Deliver care closer to the Veteran thus supporting patient centered care leading to a positive influence on patient satisfaction.

Question 7: What is the updated demographics data VA used to go from building a 70,600 square-foot facility up to a 161,525 square-foot facility in Green Bay, Wisconsin?

VA Response: *Scope Increase Justification*

- 70,600 NUSF facility was authorized by Congress (FY 2009 Appropriation)
- Projected annual clinic stops: 105,400
  - 107,000 NUSF facility was the result of adding ambulatory surgery
  - 161,525 NUSF facility was the result of a detail analysis of projected workload and added program changes.
- Projected annual clinic stops: 148,950; this is 25 percent less than actuary data: (actuary data projected workload to be 195,035)

Enrollment Factors that Contributed to Scope Change:

- OEF/OIF/OND Veterans: 2,000 active patients from Green Bay catchment, with an additional 1,500 projected to be enrolled in the next 5 years. Wisconsin has a history of high utilization of returning OEF/OIF/OND compared to VHA average (65 percent compared to 49 percent);
- Veterans receiving fee basis care: 2,743 patients from Green Bay catchment (no capacity at current CBOCs);
- Current Cost: $1.9 Million;
- Projected Priority 8 Utilization increase (2017): 1,300 Veterans (4 percent); and
- Specialty Care Programs including: Home Telehealth; Department of Housing and Urban Development/Department of Veterans Affairs Supportive Housing (HUD/VASH), tele-medicine; compliance with the Uniform Mental Health Services Handbook.

Workload Factors Affecting the Increased Scope:

- 62 percent of the increase in scope is due to workload projections.
- 25 percent of the increase is due to increased ambulatory care workload projections.
- 37 percent of the increase is due to increased specialty care, rehabilitation medicine, and surgical workload projections.

- 25 percent of the increase in scope is due to added program changes that increased the scope: Audiology (2,506 NUSF) for Compensation & Pension exams, Pharmacy (4,886 NUSF) requirements for chemotherapy and surgical needs, Radiology (5,760 NUSF) for Computerized Tomography (CT), Ultra Sound and Mammography.
- 13 percent of the increase in scope is due to space that is not accounted for in the space driver, VA's estimating space tool: Sterile Processing Service (3,065 NUSF) to accommodate surgical and dental reusable medical equipment requirements; Dialysis and Chemotherapy Infusion (4,000 NUSF) carved out of the Ambulatory Care space.

The Green Bay Outpatient Clinic will serve approximately 20,000 Veterans per year and provide primary care, mental health, ambulatory surgery, specialty care and diagnostic services. The clinic will be a regional clinic for ambulatory surgery and provide a variety of specialty care needs for Veterans traveling from the Iron Mountain VAMC to Milwaukee.

Question 8: How does the new proposed site in Savannah's accessibility to public transportation compare to the existing site's accessibility?

VA Response: Chatham County currently provides a bus stop directly in front of the current clinic, and has expressed willingness to extend the same service in front of a relocated VA clinic at the selected site, upon construction and activation, to serve the patient population.

Question 9: An expansion of the Savannah clinic was authorized in fiscal year 2009, the current facility's lease expired in 2011, and VA is now on a succeeding lease. When does VA anticipate a veteran will be able to step foot inside a new Savannah clinic?

VA Response: Based on the existing land option and value, VA had previously anticipated awarding the development contract in June 2012, with design and construction completed in spring 2014, and activation in summer 2014.

VA has re-entered negotiations with the landowner of the selected site. VA has offered to enter into an assignable option for the revised appraised value, and has offered the landowner the opportunity to commission his own appraisal of the property by August 15, 2012. If the landowner decides to commission an appraisal, and this appraisal shows a higher value than VA's appraisal, VA and the landowner will have the option of mutually selecting a third appraiser, who will review both appraisals and determine an appropriate valuation of the property. This process, if it results in a successful agreement on price, would add approximately 3 months to the timeline, potentially pushing activation of the clinic to fall 2014.

If the landowner refuses to obtain his own appraisal, or VA and the landowner are subsequently unable to reach a revised agreement on price for the preferred site, VA will cancel the solicitation. VA will then re-advertise and conduct another market survey to consider both land and existing space within the delineated area. VA will then select the procurement method that allows for maximum competition. This process is anticipated to take a minimum of 12 months, potentially pushing award until Summer 2013, and activation of the clinic to Fall 2015.

Question 10: Will VA recover the costs for the initial unqualified appraisal? If so, from whom?

VA Response: VA issued a cure notice to the real estate broker firm that contracted for this appraisal on March 29, 2012. The broker firm responded to the cure to the satisfaction of VA's Contracting Officer, by providing confirmation that all subcontractors in the future will have the requisite qualifications in conformance with Federal, and VA, requirements, and provided review appraisals from qualified appraisal firms. In the meantime, VA is investigating options available for the recovery of the costs it has incurred as a result of errors committed by VA contractors.

Question 11: Did the unqualified appraiser break the law?

VA Response: VA has no direct knowledge of whether the appraiser initially selected has broken any laws.